DEPARTMENT OF THE NAVY
NAVAL SCHOOL OF HEALTH SCIENCES
BETHESDA, MARYLAND 20889-5611

IN REPLY REFER TO:
NSHSBETHINST 5102.1B
00
JUL 18 1996

NSHS BETHESDA INSTRUCTION 5102.1B

From: Commanding Officer

Subj: SUPERVISOR MISHAP REPORT FORM 5100/1 (2/96)

Ref: (a) OPNAVINST 5100.23D
(b) OPNAVINST 5102.1C

Encl: (1) NSHS Form 5100/1 (02-96)
(2) Dispensary Permit OPNAV 5100/9
(3) Federal Employee's Notice of Traumatic Injury (CA-1)
(4) Recurrence of Disability (CA-2a)
(5) Official Superior's Report of Employee's Death (CA-6)

1. **Purpose**. To standardize the report format utilized by NSHS supervisory personnel to better enable the command to meet reporting requirements of references (a) and (b).

2. **Cancellation**. NSHSBETHINST 5102.1A

3. **Background**. Mishaps that result in personnel injury, illness, or property damage shall be the subject of a report. The severity of the loss governs the extent of the reporting. Procedures that apply to the command's mishap investigation program represent reporting requirements for on-duty military personnel, off-duty military personnel, and on-duty civilian personnel. Mishaps involving personnel will be reported in accordance with references (a) and (b).

4. **Procedures for Mishap Reporting**. All mishaps involving military personnel and civilian personnel on-duty will be reported to the supervisor immediately. Off-duty military mishaps will be reported the next work day. The supervisor shall investigate the mishap incident within 24 hours and ensure enclosure (1) is completed. The report will be routed via the Director to the Safety Officer within 5 working days after the mishap occurs. Any questions on completing the form should be directed to the Safety Officer.

5. **Responsibilities**

a. All employees are required to report all injuries, no matter how minor, to their supervisor.

b. Supervisors will ensure occupationally injured or occupationally ill persons are immediately referred or taken to the Emergency Room (ER) for emergent care. For minor injuries, members should report to the Occupational Health Department (OHD-civ.) or Military Medicine for patient assessment, documentation of injury/illness, and in-house treatment with follow-up. OPNAV Form 5100/9 (Dispensary Permit), enclosure (2), must be used by civilians when being referred to OHD or the ER.

c. All civilian employees must report to OHD for administrative purposes prior to seeking private physician assistance. If outside care is elected by civilians, the OHD may assist by calling the physician on behalf of the patient. The supervisor will refer emergent cases directly to the ER. The supervisor will keep in contact with the employee to initiate follow-up and provide assistance. If civilians receive private physician care, medical documentation must be provided to the supervisor immediately following the first visit as to the related occupational injury/illness, prognosis, and approximate date of recovery.

6. **Recording of Occupational Injuries and Illnesses of Navy Personnel**

a. **Recording Procedures - Civilian On-Duty**. The Mishap Program Manager shall maintain a log of occupational injuries and illnesses under the guidance of the command Safety Officer. Supervisors shall be responsible for reporting on-duty occupational injuries and illnesses within 5 working days after receiving information on a recordable occupational injury or illness using enclosure (1).

(1) For employees who are covered by the Federal Employees Compensation Act, any occupational injury, illness, or fatality must be reported using Department of Labor (DOL) Form CA-1, CA-2A, or CA-6(enclosures 3 - 5) to the Worker's Compensation Program.

The Information shall also be recorded on the Occupational Injury/Illness Log.

(2) The Command Safety Officer shall ensure that the command has copies of applicable compensation forms and that mishap records and logs are maintained for 5 years following the end of the fiscal year (FY) in which they relate.

b. **Recording Procedures - Military**. In accordance with reference (a), the Mishap Program Manager shall also maintain a log for military personnel mishaps.

7. **Annual Report of Navy Civilian Occupational Injuries and Illnesses**. The OSH Manager will complete and forward a copy of the report, utilizing the format prescribed in reference (a), 30 calendar days following the close of the FY to: Naval Safety Center, 375 A Street, Norfolk, Virginia 23511-4399. The report is a summary of the information recorded in the Civilian Log of Navy Injuries/Illnesses for the FY. Each Navy activity employing civilian personnel shall post an Annual Summary of Occupational Injuries and Illnesses applicable to their own activity in conspicuous places not later than 45 days after the close of the FY. The annual summary shall be left in place for at least 30 days.

8. **Commanding Officer's Review**. The Commanding Officer shall review Lost Time Mishaps with cognizant First Line Supervisors. As a minimum, this review will involve all mishaps with 5 or more lost workdays. The object of the review is to determine compliance with and adequacy of established NAVOSH standards and procedures, identify the underlying cause(s) of the mishap, and recommend corrective action to prevent recurrence. The review shall involve safety, medical, compensation, and other management personnel as appropriate.

9. **Action**. Enclosure (1) will be utilized to report those mishaps where injuries or death occurs. In addition, it will be used in all cases where there is damage to government property, regardless of personal injury.

10. **Mishap Analysis**. Activities shall conduct detailed analyses of their mishap experiences and develop annual FY mishap reduction goals. These goals shall be included in the Command goals and will specify strategies, measurement standards, and actions to be taken for goal attainment.

11. **Federal Employees Compensation Act (FECA) Claims.** Activities shall maintain records of all FECA claims for employees and shall ensure all claims are properly investigated. Intervention by the Human Resources Office (HRO) and the OHD, NNMC, is essential in potentially fraudulent claims. HRO and OHD will take immediate action when notified by the Supervisor or Safety Office of specific cases involving fraud as described in Appendix 4c of reference (a).

HARRY C. COFFEY

Dist:
List I

NAVAL SCHOOL OF HEALTH SCIENCES, BETHESDA
SUPERVISOR REPORT OF INJURY/ILLNESS

THIS REPORT SHALL BE SUBMITTED TO THE SAFETY OFFICE, WITHIN 5 WORKING DAYS OF ANY INJURY OR ILLNESS

NAME OF INJURED (LAST, FIRST, MI.)	SSN #	DATE & TIME OF INJURY

GRADE/RANK	BIRTH DATE	SEX ☐ M ☐ F

JOB STATUS MILITARY OFF DUTY ☐ MILITARY ON DUTY ☐ CIVILIAN ☐	SPECIFIC ACTIVITY AT TIME OF INJURY	PRECISELY STATE LOCATION INJURY OCCURRED

UIC	DEPARTMENT/PHONE #	☐ FATAL ☐ PERMANENT PARTIAL DISABILITY ☐ PERMANENT TOTAL DISABILITY	☐ NO DISABILITY LIKELY

MEDICAL DIAGNOSIS:	MILITARY TREATMENT PROVIDED BY: ☐ MIL. MED. ☐ OCC. HEALTH ☐ INF. CONTROL	☐ NNMC ER. ☐ PRIVATE PHYSICIAN ☐ OTHER

TYPE OF INJURY (e.g. MOTOR VEHICLE, NEEDLESTICK, SLIP & FALL)

LOST WORK DAYS		TOTAL		HOSPITALIZED		RESTRICTED ACTIVITY (LIMDU)	☐ NONE

NARRATIVE (DESCRIBE CHAIN OF EVENTS OF INJURY	DATE RETURNED TO WORK

CAUSE FACTORS: PROVIDE SPECIFICS FOR INFORMATION BELOW

A. PERSONNEL/EQUIPMENT (e.g. ATTITUDE, FATIGUE, EQUIPMENT MALFUNCTION)

B. ENVIRONMENTAL CONDITIONS (e.g. WEATHER, VENTILATION, LIGHTING)

C. PERSONAL PROTECTIVE EQUIPMENT (e.g. GLOVES, SAFETY GLASSES, SEAT BELTS)

D. CORRECTIVE ACTION TAKEN TO PREVENT REOCCURRENCE

SUPERVISOR'S REVIEW AND COMMENTS	DATE	SIGNATURE

DIRECTOR'S NAME	DATE	SIGNATURE

SAFETY OFFICE REVIEW AND COMMENTS	DATE	SIGNATURE

NSHSBETHINST 5102.1B

DISPENSARY PERMIT
OPNAV 5100/9 (REV. 1-76)
S/N 0107-LF-051-0047

PRIVACY ACT STATEMENT ON REVERSE

CASE NUMBER

SUPERVISOR'S REPORT

TO DISPENSARY *(Location)*

DATE OF REPORT

TIME & DATE OF INJURY

TIME LEFT JOB

TIME RETURNED

SOCIAL SECURITY NO.

GRADE, RATE, JOB TITLE

OCCUPATIONAL
☐ YES ☐ NO ☐ QUESTIONABLE

REASON FOR REFERRAL
☐ INJURY ☐ ILLNESS ☐ EMPLOYEE'S REQUEST ☐ OTHER *(Specify)*

REMARKS

SUPERVISOR'S SIGNATURE

SHOP/OFFICE

TELEPHONE NUMBER

MEDICAL OFFICER'S REPORT

TIME REPORTED

TIME RELEASED

OCCUPATIONAL
☐ YES ☐ NO ☐ QUESTIONABLE

TIME & DATE OF FIRST RE-TREATMENT

TIME & DATE OF SECOND RE-TREATMENT

DEGREE OF INJURY
☐ FIRST AID ☐ DISPENSARY ☐ HOSPITAL ☐ PERSONAL PHYSICIAN ☐ SENT HOME ☐ OTHER *(Explain)*

DISPOSITION OF EMPLOYEE
☐ RETURN TO PERM. JOB _____ ☐ TEMP. TRANSFER TO ANOTHER JOB ☐ TERMINATION OF EMPLOYMENT
☐ RESTRICT ACTIVITY UNTIL _____ ☐ PERM. TRANSFER TO ANOTHER JOB ☐ OTHER *(Explain)*

REMARKS

MEDICAL OFFICER'S SIGNATURE

INITIAL TREATMENT DETERMINATION
☐ DISCHARGED, TREATMENT COMPLETED ☐ RE-TREATMENT REQUIRED

Enclosure (2)

NSHSBETHINST 5102.1B

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)

2. Social Security Number

3. Date of birth Mo. Day Yr.

4. Sex ☐ Male ☐ Female

5. Home telephone ( )

6. Grade as of date of injury Level Step

7. Employee's home mailing address (Include city, state, and zip code)

8. Dependents
☐ Wife, Husband
☐ Children under 18 years
☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.

Time : ☐ a.m. ☐ p.m.

11. Date of this notice Mo. Day Yr.

12. Employee's occupation

13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code

b. Type code

c. Source code

OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

Signature of employee or person acting on his/her behalf _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

End of Employee Report

Witness

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness | Signature of witness | Date signed

Address | City | State | Zip Code

Enclosure (3)

CA-1
(Rev. 3/86)

NSHSBETHINST 5102.1B

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

17. Agency name and address of reporting office (Include city, state, and zip code) | OWCP Agency Code

OSHA Site Code

Zip Code

18. Employee's duty station (Street address and zip code) Zip Code

19. Regular work hours From: : ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

20. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

21. Date of injury Mo. Day Yr.

22. Date notice received Mo. Day Yr.

23. Date stopped work Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

24. Date pay stopped Mo. Day Yr.

25. Date 45 day period began Mo. Day Yr.

26. Date returned to work Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

27. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

29. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 31.)

30. Name and address of third party (Include city, state, and zip code)

31. Name and address of physician first providing medical care (Include city, state, zip code)

32. First date medical care received Mo. Yr.

33. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☐ Yes ☐ No (If "No," explain)

35. Does the employing agency controvert continuation of pay? ☐ Yes (If "Yes," explain) ☐ No (See instructions for explanation of "controvert")

36. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

38. Filing instructions
☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
☐ No lost time, medical expense incurred or expected: forward this form to OWCP
☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

Enclosure (3)

CA-1
(Rev. 3/86)

NSHSBETHINST 5102.1B

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employee's behalf)

13) Cause of Injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg; cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and file CA-1 within thirty days of the injury, you are entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.) Also, if you later change your election, the agency is not obliged to convert past periods of leave to COP.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within two working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

29) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

31) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

32) First date medical care received

The date of the first visit to the physician listed in item 31.

35) Does the employing agency controvert continuation of pay?

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability results from an occupational disease or illness;

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is neither a citizen nor a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred six months or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Notice Of Employee's Recurrence Of Disability And Claim For Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

IMPORTANT: Before completing this form please read carefully the instructions.

PART A – EMPLOYER

1. NAME OF INJURED EMPLOYEE *(last, first, middle)*	2. SOCIAL SECURITY NUMBER	3. OWCP file number for original injury *(if known)*
4. HOME MAILING ADDRESS *(include zip code)*		5. HOME TELEPHONE Area Code Number
6. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of original injury *(number, street, city, state, zip code)*	7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of recurrence, if other than 6.	

8. DATE AND HOUR of original injury *(mo., day, year)* ☐ a.m. ☐ p.m.	9. DATE AND HOUR of recurrence *(mo., day, year)* ☐ a.m. ☐ p.m.	10. DATE AND HOUR stopped work following recurrence *(mo., day, year)* ☐ a.m. ☐ p.m.	11. DATE AND HOUR pay stopped following recurrence *(mo., day, year)* ☐ a.m. ☐ p.m.

12. PAY RATE IN EFFECT ON:	a. Base pay	b. Subsistence	c. Quarters	d. Other pay
A. Date of Recurrence	$ per	$ per	$ per	$ per
B. Date Stopped Work Following Recurrence	$ per	$ per	$ per	$ per

13. Show work week at time pay stopped, if other than Monday thru Friday S M T W T F S	14. DATE AND HOUR returned to work, following recurrence *(mo., day, year)* ☐ a.m. ☐ p.m.	15. At time of recurrence did official superior authorize medical treatment? ☐ YES ☐ NO
16. DATE employee first received medical treatment following recurrence *(mo., day, year)*	17. NAME AND ADDRESS of physician treating employee following recurrence	

18. After returning to work following the orignial injury, was the employee handicapped or in any way limited in performing his/her usual duties? ☐ YES ☐ NO *(If yes, explain)*

19. Describe the circumstances of the recurrence of disability as reported by the employee. If the condition gradually worsened over a period of time, describe the progress of the condition from the time employee returned to work up to the date of recurrence.

A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

20. Signature of official superior *(at time of recurrence)*	21. Title	22. Official superior's work phone number	23. Date *(mo., day, year)*

Form CA-2a
Revised February 1984

Enclosure (4)

PART B – CONTINUATION OF PAY

24. Inclusive dates that employee's regular pay continued during this period of recurrence. Do not include period of sick or annual leave. *(mo., day, year)*	25. Show gross dollar amount of regular pay which employee received during this period of recurrence.
From: Through:	$

26. If pay changed during the period employee was receiving continuation of pay, for this recurrence, show date of change *(mo., day, yr.)*.	27. If pay rate changed during the period employee was receiving continuation of pay, give new rate.			
	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(specify)*

PART C – EMPLOYEE

28. Complete this item if you worked during the period shown in item 29(b) or 29(c).

a. Dates & Hours Worked	b. Pay Rate *(per hour, day or week)*	c. Total Amount Earned	d. Type Work Performed	e. Name & Address of Employer

29. I certify that the recurrence claimed on date in item 9 was due to the injury shown in item 8 and I hereby claim medical treatment, if needed, and the following as checked below, while disabled for work:

☐ a. Sick and/or annual leave

Period: From: Through:

☐ b. Continuation of regular pay not to exceed 45 days, which will include days taken during the original injury and prior recurrence(s), and compensation for wage loss if disability for work continues beyond 45 days. *(If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).*

Period: From: Through:

☐ c. Continuing compensation on account of occupational disease.

Period: From: Through:

30. Signature of Employee or Person Acting on his/her behalf. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imrprisonment, or both.	31. Date *(Month, day, year)*

☆U.S. GOVERNMENT PRINTING OFFICE: 1986-150-940/49342

Enclosure (4)

INSTRUCTIONS FOR COMPLETING FORM CA-2a
RECURRENCE OF DISABILITY

DEFINITION OF RECURRENCE

When after returning to work, an injured employee is again disabled and stops work as a result of the original injury or occupational disease, such disability is considered by the Office of Workers' Compensation Programs (OWCP) to be a recurrence. In these instances Form CA-2a is required. If a new incident occurs, the matter should be treated as a new injury and Form CA-1 (traumatic injury) or Form CA-2 (occupational disease) submitted accordingly.

INSTRUCTIONS

- Form CA-2a is used to report an employee's recurrence(s) of disability for traumatic injury and/or occupational disease. Part A must be completed by the employing agency in every case. Part B must be completed by the employing agency in traumatic injury cases only. Part C must be completed by the employee or someone acting on his/her behalf.

- Form CA-2a should be submitted promptly by the employing agency upon receiving notice that the employee has suffered a recurrence.

- If the original injury was not previously reported to OWCP, a report specifically covering the original injury should be made on Form CA-1 (traumatic injury) or CA-2 (occupational disease) and attached when Form CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted.

- If this is a recurrence of an occupational disease, the employee may claim wage loss on Form CA-4 if this form was not submitted following original injury. If Form CA-4 was previously submitted, compensation beyond the date Form CA-2a is signed, may be claimed on Form CA-8.

- If this is a recurrence of a traumatic injury, and the 45 Continuation of Pay (COP) days have been exhausted, the employee may claim wage loss beyond the date Form CA-2a is signed on Form CA-7. If Form CA-7 has been filed previously, wage loss beyond the date Form CA-2a is signed may be a claimed on Form CA-8. The OWCP will be responsible for payment of compensation if the claim is approved.

- Where pay is continued, the employing agency should obtain medical evidence on Form CA-17, "Duty Status Report", as often as circumstances indicate.

- If the recurrent disability has not ended at the time Form CA-2a is submitted, Form CA-3, Report of Termination of Disability and/or Payment, should be forwarded when the employee returns to work.

- If the recurrence happens less than six months following employee's return to work following the injury, the supervisor shall authorize required medical care by use of Form CA-16. If the recurrence happens more than six months after the employee's return to work, authorization for further medical care must be obtained from the OWCP.

- When the employee has received medical care as a result of the recurrence, a detailed medical report should be submitted by the attending physician. The report should include: dates of examination and treatment; history given by the employee; findings; results of x-ray and lab tests; diagnosis; course of treatment, and the physician's opinion, with medical reasons, regarding causal relationship between employee's condition and the original injury.

- If the employee was treated by other physicians after returning to work following the original injury, similar medical reports should be obtained from each.

- If the recurrence happened six months or more after the employee returned to duty following the original injury, A STATEMENT FROM THE EMPLOYEE MUST ACCOMPANY FORM CA-2a. The statement should describe the employee's duties upon his/her return to work, state whether he/she had any other injuries or illness and give a general description of his/her physical condition during the intervening period. The employee should explain why he/she believes the present condition is related to the original injury.

NSHSBETHINST 5102.1B

Official Superior's Report of Employee's Death

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

1. Name of Deceased Employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. ☐ Male ☐ Female	4. Social Security No.

5. Department or Agency	6. OWCP Agency Code	7. OSHA Site Code

8. Name and Address of Reporting Office	9. Name and Office Phone Number of Employee's Official Superior

10. Date and Hour of Injury (Mo., day, year) ☐ AM ☐ PM	11. Date and Hour of Death (Mo., day, year) ☐ AM ☐ PM	12. Date and Hour Employee's Pay Stopped (Mo., day, year) ☐ AM ☐ PM

13. Describe how injury occurred	14. Was employee in performance of duty when injury occurred? ☐ Yes ☐ No (if No, explain):

15. Location where injury occurred	16. Location where death occurred	17. Immediate cause of death (Attach medical and autopsy report if available)

18. Employee's pay rate as of	a. Base pay	b. Subsistence	c. Quarters	d. Other
A. Date of injury	$ per	$ per	$ per	$ per
B. Date pay stopped	$ per	$ per	$ per	$ per

19. Did employee work in position held at time of injury for a full eleven months immediately prior to the injury? ☐ Yes ☐ No	20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? ☐ Yes ☐ No

21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates) From To	22. a. Occupation code	b. Type code	c. Source code

23. Did employee receive continuation of pay (COP) during period prior to death? a. Pay rate used for COP $ per	b. Inclusive dates of COP From To	OWCP use - NOI code

24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number:	25. Show date through which HBS deductions were last made (Mo., day, year)	26. If employee received medical care prior to death, give name and address of attending physician

27. If injury was caused by a third party, give name and address of third party	28. Give name and address of the attorney representing the survivors if legal action is instituted against the third party	29. Show amount of third party recovery, if any $

30. If employee was a member of the Armed Services of the United States, show: Branch of Service: Serial No. (If known)	31. Has claim for survivor's benefits been filed with the Office of Personnel Management? ☐ Yes ☐ No

32. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse)

33. Signature of Official Superior	34. Title	35. Date (Mo., day, year)

Enclosure (5)

Form CA-6
Rev. Nov. 1986